WORLD HEALTH

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the poorest of the poor

To support the poorest of the poor

by Mohamed Abdelmoumène

Deputy Director-General of the World Health Organization

For more than 40 years, WHO and its Member States have been working together to improve the health of the world, and to ensure that not a single person should be deprived of one of the fundamental rights: to attain the best possible state of health.

During recent decades, WHO has recorded many successes. Foremost of these is the example of smallpox, which has disappeared from the surface of the globe, and to that we can add the decline in infant mortality that most countries have reported.

And yet, despite the close partnership that has constantly existed between WHO and the countries, the health situation of whole populations in many regions of the world remains at unacceptable levels.

This is why WHO has launched a new initiative which gives top priority to the countries and populations which are most in need. The Organization thus commits itself wholeheartedly to support the poorest of the poor in their struggle for a better life.

Faithful to its intention of attaining Health for all through primary health care, WHO intends to find new ways of managing health care and identifying human and financial resources. At the same time, WHO will embark on a much more concrete policy of action at country level, so as to turn its partnership with member states and with other international organizati into a truly effective weapon aga the social and health consequence poverty.

The poorest countries often h great difficulty in accurately analy situations, putting integrated strate into effect and managing their mea resources rationally.

Moreover, the work of the inte tional organizations and even tha the different programmes of WH often insufficiently coordinated at national level. This can lead situations where certain activities duplicated while others – which m well be the most essential – are sa lacking. WHO as well as its mem countries are ready to re-think direction of their efforts and to re-c the firmly held notions of the past, as to create a new approach which truly permit ideas to be transform into concrete realities.

The countries have commit themselves to taking a long hard lo at their priorities in the light of resources at their disposal, even if t might oblige them to start fr scratch.

For its part, WHO commits itself re-examine the way its own resour are allocated, to show more flexibi in the use of funds within the cou

tries, and to ensure a better integration of its activities.

Over and above all this, the Organization will further reinforce the offices of the WHO representatives in the countries concerned, since they will have a crucial role to play in the new initiative. The WHO representatives will assist the countries to improve their capacity for planning, programming and management in the health sector, so as to arrive at better-integrated, well-coordinated and more realistic national health plans. They will thus seek to harmonise international health activities in such a way as to ensure that the health services use resources to the best possible advantage, serving all the population without exception. WHO hopes in this way to succeed in anchoring its activities in the very heart of each country, and bringing about a truly effective partnership. ■

Mothers with their children in Haiti, a waterlogged slum in Indonesia, a girl picking over a city rubbish-tip in Egypt. "Despite the close partnership between WHO and the countries, the health situation of whole populations remains at unacceptable levels."

READEX FICHE

Cover: Roofless and rootless, a migrant family beds down on a city pavement in the Philippines.
Photo WHO/Zafar

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More than a billion . . .

by Michel Jancloes

Even though the number of inhabitants of our planet living in good sanitary conditions has considerably increased during the last two decades, we have to admit at the same time that the absolute total of people living in unacceptable conditions of poverty has also risen. Today there are more than one billion such people.

Where do they live? Sometimes at our very doorstep, hidden behind a façade of gentility. Sometimes whole cities of such people have grown up quite recently – and even whole provinces, whole regions of large countries. All these have to be added to those who live in what we call the least developed countries.

It is estimated that close to 2,200 million people live in a state of severe poverty, and among these more than 700 million belong to the category of extreme poverty. Almost 60 per cent of the inhabitants of the least developed countries (LDCs) survive under very precarious conditions, but in the developing countries generally the total of under-served people share the same fate and the same characteristics:
– large families;

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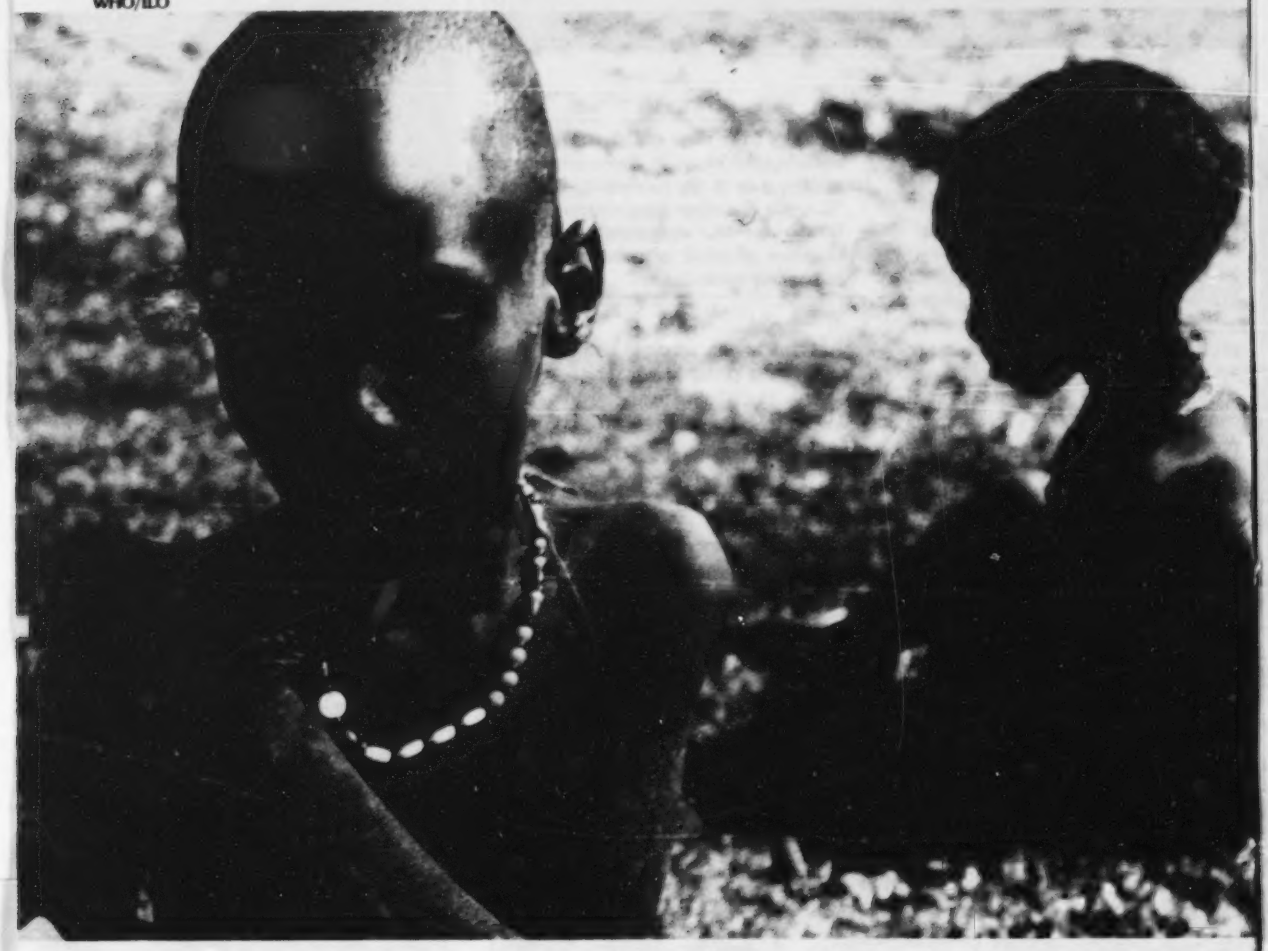
WHO/ILO



Famine victims in Africa; what chance have they and their like of even staying alive until the year 2000? Facing page: A congested slum in the Western Pacific. Ever greater numbers are herded together in urban "ghettos" that lack satisfactory sanitation.

extremely low earnings:
- 75 per cent of this population live in he countryside while the remainder re grouped together in urban "ghet-os" lacking in decent sanitary facilities;
- 80 per cent of their earnings are pent on food, and yet malnutrition is idespread;
- nine out of ten people have no ccess to safe drinking water;
- the level of health is very low, and he targets of primary health care have ot been achieved;
- out of every 1,000 live births, 130 abies never reach their first birthday;
- nearly one child in four is of low irth weight, while fewer than half of he mothers will have received ade-uate care from qualified personnel luring their pregnancies;
- only one child in seven will have the ood fortune to receive the right accinations against diphtheria, tetanus nd whooping-cough;
- life expectancy at birth is no more han 47 years.

The list could run on much longer. Equally, we could look for some sort of explanation, if not justification; we could blame the remoteness of countries or regions, economic dependence, political instability, management problems, susceptibility to external factors – whether climatic or economic. But in the end, we are left with men, women and children who would have just the same chance as anyone else to live in a dignified manner if only the technological means that we already have could be applied to reduce the yawning gap between the haves and the have-nots.

No lack of resources

This situation does not lend itself to improvement since – on a global scale – the human, financial and technological resources are already quite sufficient to prevent the tragic consequences listed above.

In such an environment of deeply entrenched poverty, activities in the field of health development take on a very special meaning. These activities do not only serve to meet a fundamental right of every human being; they are at the same time the only valid strategy to break the vicious cycle of sickness-poverty-more sickness, and to create instead an upward spiral of health-and-development capable of crystallising the forward advance of each community's social and economic system.

Least developed countries

The term "least developed (among developing) countries" – abbreviated as LDC – has a collective meaning and is the specific term that applies only to those countries recognised as such by the General Assembly of the United Nations. As from the start of November last year, the list of the least developed countries included the following 42 nations:
Afghanistan, Bangladesh, Benin, Bhutan, Botswana, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Comoros, Democratic Yemen, Djibouti, Equatorial Guinea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Malawi, Maldives, Mali, Mauretania, Mozembique, Myanmar (formerly Burma), Nepal, Niger, Rwanda, Samoa, Sao Tome and Principe, Sierra Leone, Somalia, Sudan, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen. ■

International solidarity and cooperation must respond to this challenge which every day faces all those of us fortunate enough to be able to appreciate life in all its beauty. ■

Born underprivileged

by Fredj Stambouli

Still rooted in the economic and political system that arose during the last century, the world today is polarised between the exceptional opulence of the industrialised world and the grinding poverty and deprivation that is widespread in least developed countries. This phenomenon is aggravated by the fragility of Third World societies, the result of years of historical stagnation and subservience within the triumphant capitalist system.

Remember that there are 5,000 million people in the world today, twice as many as in 1950. This figure will rise to more than 6,000 million by the year 2000, three-quarters of them living in the Third World – where 90 per cent of the population increase expected over the next decade will take place.

Certain "at risk" groups in society – women and children, the old, the handicapped, the refugees – bear all the weight of poverty. Neither minority nor marginal, they are a massive and continually growing population, estimated at 1,000 million individuals throughout the world, and most of them are in developing countries. Their living conditions are precarious, they are excluded and culturally alienated, and they play no part what-

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"High-rise" living in India and, facing page, women carrying out heavy manual work in Nepal. "The precarious housing and health of 2,000 million people are compounded by a dangerous environmental situation, and by sheer hunger."

WHO/Aqa Tokola

ver in decisions about their present nd their future. This is the current ondition of half the population of the Third World and 70 per cent of the opulation of Africa!

The recession, the burden of debt, nd the urban explosion – in certain leveloping world cities, up to half the opulation lives in shanty towns – all ontribute to this extreme poverty, vhich has disastrous effects on hous-ng, health, employment, nutrition and ducation. The precarious housing nd health of 2,000 million people in he world, 60 per cent of the popu-ation of developing countries, are compounded by a dangerous environ-mental situation, and by sheer hunger. As the Brundtland Commission eported: "There are more hungry people in the world today than there have ever been."

Maternal deaths

A woman born poor in a developing country is 150 times more likely to die n pregnancy than a woman born in an ndustrialised country. Most of the 500,000 maternal deaths each year occur in developing countries. The direct causes of that situation are lack of information and appropriate services, and poor nutrition: in South-East Asia and Africa for example, 65 per cent of pregnant women suffer from nutritional anaemia.

There is also a lack of money. Most women – even heads of households – have trouble finding employment, and prostitution is steadily on the increase, especially in Asia and Africa. Furthermore, the village traditions of solidarity and mutual assistance have been so weakened that they are no longer able to protect women. Underlying this is a long history of sexual inequality which the economic crisis seems to aggravate, in spite of timid social changes here and there, which are invariably distorted, sometimes with an element of feminism borrowed from abroad.

Poor women, therefore, are especially vulnerable, and this has repercussions for their children. Infant mortality has been halved in 15 years. Yet the prospects are not good, since several million children who survive grow up in conditions that prevent them realising their physical and mental potential.

In developing countries, moreover, one child in three dies before the age of five and 45 per cent of those deaths are caused by diarrhoea and intestinal infections. Respiratory infections and nutritional deficiencies, which are closely tied to living conditions in shanty towns and slums, are the two other major causes of morbidity and mortality in young children: they kill three million each year.

Energetic vaccination campaigns have achieved a great deal over the last ten years, with as many as 46 million children vaccinated every year. And yet almost 2.8 million children still die of avoidable diseases such as poliomyelitis, tetanus, measles and tuberculosis. A further three million children suffer the sequelae of those diseases for the rest of their lives. Malnutrition is an aggravating factor that reduces the birthweight of children – to less than 2,500 grams in one-third of cases – and leads to infectious diseases in young children.

It is forecast that there will be 1,200 million old people in 2025, 70 per cent of them in developing countries. Their predicament in those countries is particularly alarming, since many of them leave their villages to swell the immense populations of the shanty towns around big cities.

As Dr Hiroshi Nakajima, Director-General of WHO, recently pointed out, in many developing countries, the old follow the young to cities where they

have to struggle for living space in the big shanty towns. Worse still, they have little chance of finding work in areas of mass unemployment. This is a most urgent problem since almost 65 per cent of the world's population will be living in cities by the year 2030. In the almost total absence of solidarity and social protection that has resulted from the fragmentation of the family, the situation of old people is quickly becoming tragic.

There are about 500 million handicapped people in the world today, and this figure is expected to double by the year 2000. Four-fifths of them live in the Third World, where one-third of the handicapped are children. They have the same problem of escaping poverty and making progress as other risk groups. On top of that, the vicious circle of poverty and the weakening of social and cultural structures create situations that themselves cause handicaps.

Refugees, of whom there are between 13 and 14 million in the world today, constitute a massive presence in Asia, Africa and Central America. Mass migrations are a new phenomenon caused by the global nature of the economy and of society.

The last decade has witnessed great famines caused by a hostile environment, which have sent wave upon wave of human beings to neighbouring countries which have hardly enough food to feed their own populations. Besides the quest for a better standard of living, wars and violent repressions have also sent whole populations into self-imposed exile.

Two million homeless

The scale of the problem can be staggering, as in the case of the three million Afghan refugees in Pakistan, 75 per cent of whom are women and children. The drama of that situation is compounded by the fact that Afghanistan was fighting a civil war not of its own making, where at least two million people were driven from their lands and homes and made into refugees elsewhere in their own country. In the words of the UN High Commissioner for Refugees: the situation cannot be improved unless the great powers make a determined effort to achieve a lasting peace.

To improve the living conditions of risk groups in society is a prerequisite for world health and it should be an absolute priority for the authorities everywhere. Providing more than 1,000 million poor people with acceptable living conditions is a daunting problem indeed. WHO itself selects priorities and activities to be carried out in its programmes. But real success in this area depends on radical changes taking place at global and national levels. These should be of three orders:
– the encouragement of coordinated, multi-sectoral community development in each country;
– assistance in restructuring the global, political and economic order so as to correct the serious North-South imbalance and give the peoples of the Third World a chance to find their feet;
– transformation of our whole way of thinking in order to set up new forms of development, cooperation and solidarity throughout the world that can meet the challenges of our time. ■

NEPAL

Sight for the blind

by Nedd Willard

Sir John Wilson's speech to the annual meeting of WHO's Regional Committee for South-East Asia in 1976 had deeply moved all those present as they heard of the tragic situation facing the blind in developing countries. And Sir John, then President of the International Agency for the Prevention of Blindness, went on to pose the question: "After smallpox eradication why not the prevention of blindness?"

One of those who took up this challenge was Dr Ram Prasad Pokhrel, a dedicated Nepali ophthalmologist, who was convinced that Nepal might be the place to launch a nationwide campaign against blindness, even though Nepal was one of the most physically arduous and economically least developed countries in the world. And, if the campaign could succeed in Nepal, would it not be a sign that it could succeed elsewhere under less daunting conditions?

Equally convinced was Dr Nicole Grasset, who had just completed her job as leader of the smallpox eradication programme in South-East Asia, where she had seen children and adults robbed of their sight by smallpox. Both of them were aware that in developing countries more than two-thirds of all blindness can be prevented or remedied.

The first task was to assess the situation accurately. In the beginning there were no hard data about how many people were blind and what was the distribution of blindness. The one thing that seemed sure was that the vast majority of cases of blindness could be either prevented or cured by treatment or operation. And that was a good reason to press on.

Planning is the least glamorous, but in many ways the most vital part of a health campaign. Some had surmised that the main problem in Nepal might be trachoma. However if, as an early pilot study seemed to show, the real problem was unoperated cataract and trachoma represented only a small part of the problem, that meant a different sort of programme had to be set up.

Dr Nedd Willard, formerly a Public Information Officer at WHO's Geneva headquarters, is now a member of the Board of Directors of the Seva Foundation in San Rafael, California, USA.

To work more effectively, Dr Grasset and former colleagues from WHO's smallpox eradication programme set up a voluntary non-profit organization devoted to the relief of suffering, called the Seva Foundation.

Funds were made available by the Dutch government to carry out a survey and to begin the eye programme. It was to be executed by WHO's newly formed Prevention of Blindness programme, working in collaboration with the Nepalese Ministry of Health.

International organizations were already working in Nepal, but their work was largely confined to the main eye hospital in Kathmandu or to specialised centres. This new project was an ambitious scheme to survey the entire country and eventually furnish Nepal with the means to tackle its problems on a nationwide scale and become self-sufficient in personnel.

Nepal lies like a bumpy blanket 110 miles wide and 500 miles long,

Nepal: sight for the blind

stretching from the world's highest mountains to the flat, hot plains that border India. With a population today of over 18 million, it has a high infant mortality rate of 130 deaths for every 1,000 live births; a sure indicator of poverty and under-development. Life expectancy is only 48 years.

The nationwide survey of blindness in 1980 was the first ever carried out in a developing country. Right from the beginning, Nepalis were associated at every step of the way. For several young people, their work in the survey proved to be the first step towards a professional career in saving sight. For example, some who had acted as census-takers went on to become ophthalmologic assistants. And these men and women represented the broad ethnic and cultural tapestry that forms the Nepalese nation.

Survey results

In all, 105 villages were visited and half of them required the arrival of the doctors by helicopter. Other staff arrived on foot after hard days of trekking. The survey results helped to determine the pattern of blindness in Nepal. Two-thirds of the cases of blinding trachoma, for instance, occurred in one area of the Terai, the flat region bordering India, in a district not more than 75 miles in circumference.

But the main cause of blindness showing up starkly was that of unoperated cataract. The first major undertaking was to train Ophthalmic Assistants (OAs) to work under the supervision of ophthalmologists, both to find cases needing attention and to assist during surgical operations. Even before the survey was completed in 1981, the training of OAs had begun. Many of them went to the Aravind Eye Hospital in Madurai, India, which is famous as a model of kindly, low-cost care and efficient skills in action. Aravind agreed to train these young people without charging fees for tuition.

The setting up of the WHO/Nepali national programme for blindness prevention involved – besides the Nepal Red Cross, Lions Club and Rotary – such groups as the Association for Ophthalmic Cooperation in Asia, the Christoffel Blinden Mission, the

WHO/N. Willard

WHO/N. Willard

Many villages visited during the Nepal survey required hard days of trekking by the census-takers. Top: ***Dr R.P. Pokhrel checks returns from a national blindness survey.***

Japanese International Cooperation Agency, the Netherlands government, Norwegian Church Aid, the Organisation pour la Prévention de la Cécité, Operation Eyesight Universal, Seva in Canada and the United States, and the Swiss Red Cross.

From a modest office on the outskirts of Kathmandu the programme went to work. There was need to do a great deal with few trained people, and in a hurry, if goals were to be met and results were to justify the programme. Medical facilities had to be built, in keeping with the scale of the project and the climatic conditions. Nepali doctors had to be trained in ophthalmology and other skills. Eye operations had been few in number; they had to be drastically increased and made available to remote regions.

But the effort called forth new dedication, and resulted in moulding an eager group of people with a variety of specialities and backgrounds into a winning combination. Foreign consultants and volunteers with experience in eye surgery were flown in, often at their own expense, to work in remote centres, doing operations in schools and tents, often during the night in the gleam of flashlights. Meanwhile more Nepali counterparts were being trained who would soon take over.

"Remember," Dr Pokhrel explained, "in 1980 the number of people blind in Nepal, a country of only 15 million people, was equal to that of the United States with 230 million." The number of operations had to be greatly increased to cover people needing operations each year, as well as the backlog of those who had long been waiting for an operation. In 1980, with only about 1,200 operations in all of Nepal carried out by seven ophthalmologists, that seemed an impossible dream.

Taking a leaf from India's book, eye camps were scheduled in rural areas. These large temporary camps are set up so that operations could be carried out en masse. The camps are effective; they bring physicians to rural people and demonstrate dramatically and conclusively that such operations can restore sight.

In the one year 1987, nearly 78,000 cataract operations were performed. This was enough to take care of new cases and help reduce the backlog of those who were waiting. In 1981, when the programme began, there were only seven ophthalmologists in Nepal, most of them working in the capital. Today there are 45 eye surgeons to cover the whole country. From 28 beds for eye patients, the number has risen to 625. From three small rural eye departments, the number has risen to 17 well-equipped eye hospitals and centres.

Dr Pokhrel has now taken over full responsibility as manager of the national programme. He is also a member of WHO's Programme Advisory Group for the Prevention of Blindness. Under his leadership, a national committee has been formed and this includes several non-governmental organizations which now work in Nepal following up the initiative taken by Seva.

NEPAL is a kingdom set in the Himalayas, with Kathmandu as its capital. Bordered by China and India, its area is 56,100 square miles and its population 18,760,000. ■

Above all, Nepal has become almost self-reliant in eye-care personnel in little more than eight years. In addition to eye-care specialists, 332 District Medical Officers and 48 health inspectors have been trained about preventable blinding conditions. Primary eye-care delivery at the village level is being expanded through the training of various types of community health workers.

That doesn't mean there are no problems left to solve. There is considerable ignorance about cataract blindness; many people consider it is an irreversible and inevitable result of aging. To deal with the problem of ignorance, continuing campaigns of health education use radio, posters and word of mouth.

And to pull the patchwork of eye services together in this country separated by arduous miles of mountains, citizens from many countries are working together under leadership from the Nepalis to ensure that every person in Nepal who requires an operation to restore the precious gift of sight receives it. ■

KIRIBATI

The healthiest island

by Iwan Soetjahja

"This trophy will stay in Mayana!" cried Taketiau, the representative from the Island of Mayana and Chairman of the island's Village Welfare Group (VWG). He held up the trophy on the podium to show it proudly to all present at the National Independence Day Celebration on 12 July, 1985. He had just received the trophy from the President of Kiribati (previously known as the Gilbert Islands). His island of Mayana had just won the prize for the most healthy island in the country.

Dr Iwan Soetjahja is Regional Adviser in Health Education at WHO's Regional Office for the Western Pacific in Manila.

With a population of 64,000 people spread out over 22 of its 33 small islands in a Pacific ocean area as big as the United States, Kiribati is one of the least developed countries in WHO's Western Pacific Region. Yet with much hard work and perseverance, it has been able to plan and build a national health care service. The system is based on developing nationwide community self-help groups as the main way of applying the primary health care approach. These health-related activities have been developed and maintained by means of health education and its related activities.

The national health plan provides support at the central level for health education and community organization. The health staff of the maternal and child health and family planning services were encouraged to set up VWGs within each community and train them to arrange health education talks and personal discussions with fellow villagers. Public health nurses and medical assistants were advised on how, when and where to provide their services. They were also trained to initiate health-related activities at village level, working with community leaders.

After the national health plan was completed in 1982, three manuals were produced showing how to carry it out. With these, all the public health nurses and medical assistants in the islands were oriented and

The coveted trophy for the healthiest island in Kiribati is handed over to the representative of Mayana. Below: Mothers who have learnt to read are much more likely to bring their children regularly for immunization.

WHO/UNICEF

WHO/I. Sotiplija

trained. The manuals also explain how to run village welfare groups and train them to provide simple health education and improve the health of the community.

One Saturday morning in 1983, a WHO tuberculosis consultant had to determine the effectiveness of BCG vaccination on Makin Island before he returned to Manila the following day. The village welfare group chairman was given the difficult task of getting the schoolchildren together even though it was a holiday. In two hours' time, the expert was busy checking the BCG scars of all the schoolchildren in Makin.

When diarrhoea broke out in the same island in June 1983, the village welfare groups were quickly mobilised to help overcome the problem. Not only the VWGs are health-aware. Mothers have been motivated to bring their babies for immunization at the village *maneaba* (meeting house). Some fathers have built water-sealed latrines and wells for their homes under the guidance of the VWG members. Tuberculosis and leprosy patients who had dropped out of the treatment schedule have been encouraged to come back to the clinic for examination and drug therapy. Households have been taught about nutritious vegetables and how to grow them in the barren Kiribati coral sand; the village welfare groups even distributed seeds.

KIRIBATI, formerly the Gilbert Islands, comprises 33 islands in mid-Pacific. Its land surface of 266 square miles sustains a population of 64,000, and the capital is Tarawa. ■

It was because so many activities of this kind were carried out by the VWGs that Mayana won the first prize for health. Various health promotion activities and incentives encourage communities to compete for the health prize. For example, the national health flag can only be raised on the winning island, and there is a national health song which is sung during special ceremonies. A National Health Holiday is celebrated on 9 May each year to remind people of the importance of keeping healthy and the value to Kiribati of being a member of WHO. Continuous support activities are undertaken by the members of the Primary Health Care Parliamentarian Committee, founded in June 1985. And the fact that the Ministry of Health is now one of the better organized ministries in the country has helped to give health programmes good popular support in Kiribati.

Convinced of the importance of health education support, 13 countries in the Western Pacific Region have embarked on programmes to improve it, with careful planning in advance of how to carry them out and evaluate the results. At the same time, research in this field is increasing, and more and more people are being trained to work as health educators. ■

NIGERIA

Self-reliance in the village

by M.C. Asuzu

It has become a generally held cliché that there are no universally applicable models for primary health care (PHC). It is also now commonly realised that the original "PHC approach" to the movement for Health for all by the year 2000 should be a development of PHC services which harmoniously combines a "top-down" institutional component as well as a "bottom-up" grassroots component.

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Bottom-up PHC enthusiasts have mostly had a background of work with voluntary, missionary and research agencies as community health development officers, and have often emphasised the development of PHC services in indigenous communities, especially those that are not served by the local, "institutionalised" health services. The case history below and the discussion which follows illustrate one of many possible and, in my view, very appropriate models of bottom-up PHC developments that we at the Department of Preventive and Social Medicine, Ibadan College of Medicine, Nigeria, had the privilege of developing through our own PHC efforts. Perhaps it may prove useful to other people in situations similar to our own.

Elesu Community PHC Programme

Elesu is a hamlet of some 700 people lying some 32 kilometres north of Ibadan in Oyo State, Nigeria. After one of its regular guinea worm disease epidemics in January-March 1985, one of its sons, a junior hospital worker who knew about our involvement with guinea worm eradication and PHC programmes, sought our help for his village. We made two visits to the village at the young man's expense to spot-evaluate the epidemic, to carry out individual treatment and follow-up of the people in the community afflicted by the disease, and to decide what steps to take.

WHO/D. Henrioud

Once the village development committee had been convinced about primary health care, the community itself took sole charge of many health-related activities.

During the second visit, we had talks with the village head (the *Baale*) and with the community leaders he brought with him. We discussed at length possible community action for the immediate control and the long-term permanent eradication of guinea worm from the village. We explained how the causative agent works, its life cycle and the mechanisms of epidemics, and suggested different approaches to clean water supply, purification and safe-guarding of water sources. We emphasised community self-reliance and the possibility of using this opportunity to identify and solve other community problems within a PHC framework.

After that, we heard nothing else from the village until late in 1986, except that it had experienced another guinea worm epidemic in December 1985 to April 1986. By the time they contacted us again in September 1986, the village had formed a village development (health) committee (VHC), as had previously been proposed in early 1985. The committee had collected money from the community to build a sanitary community well, but the money had not been enough so they now wished to try the first alternative we had proposed – using individual monofilament filters to purify household water from the community pond.

The VHC was put in touch with the source of the monofilament filters, and went ahead to buy these filters at the rate of one per household. They learnt how to use them and then taught and supervised the rest of the community

embers in their use. Once they saw e tiny cyclops-infected water-fleas mping out of the filters as the water ained through them, the community came fully convinced about the way inea worm disease was caused. They cided to adopt the entire PHC ckage as proposed to them in 1985.

From that decision in September 986 up to June 1989, the pro-ammes and activities within the esu PHC programme carried out lely by the community have included besides filter control of guinea worm making a community census of the tire village and its resources (e.g. trines, bathrooms, schools, traditional ealers and so on), starting household ealth records, demonstrating prepar-ion of local foods for better nutrition, aking a start on building two latrines, nd finding accommodation for a llage health clinic.

What we did with substantial com-unity participation included running monthly village health clinic, training wo villagers in how to improve the ocal diet, training village health orkers (VHWs) in oral rehydration herapy, and building the first really anitary well in the centre of the village. ith the help of the local government uthorities.

What we hope to do shortly is to set p a village drug store to be run on a ost-recovery basis, to start a village eed nursery for the local farmers, and o make a survey of intestinal worm nfection among schoolchildren as a aseline index of community environ-nental health.

A total lack of any external funding or this programme made it impossible o do most of the other things we would have liked in the community.

All data on the village had been collected by community members and were cross-checked by us as far as possible. Transport for these monthly visits was provided by a wealthy son of the village who lives in Ibadan, as his contribution to the village's develop-ment. Six candidates (two men, four women, two illiterate, four semi-literate) were selected by the com-munity for training as village health workers.

The monthly meeting with the VHC is largely to review the health activities carried out in the community, to map out what to do for the next month, and to give such advice or help as we can. The clinic that follows the VHC meeting is held mainly to provide the sugar coating for the sometimes unde-sired pill of preventive and promotive health care, which is the essence of all community health programmes includ-ing PHC. We expect to be able to replicate this programme in any local community that is ready to take charge of its needs for PHC as the Elesu community has.

This case history shows that, when community health development workers are available and willing to go out and assist communities, it is pos-sible for them to come forward to request and be helped to provide community-owned and self-reliant PHC programmes for themselves. Even where they don't come and ask for it, it should be easy for community health development professionals to seek out villages that show evidence of high motivation and to establish PHC for them through the classical out-going approach of professional com-munity health practice. Once such PHC programmes have developed full community self-reliance, however, they need to be handed over to the local, statutory health care institutions so that the community health profes-sionals can move on to set up more such PHC programmes elsewhere.

Funding agencies should consider the provision of transport facilities as a very important way of helping com-munity health professionals in developing countries. Not every com-munity has wealthy sons to provide free transport as Elesu has!

With appropriate development of community health and PHC in the developing countries, it is important for the pill of preventive medicine to be given with the sugar coating of curative care – even though the pill may be in the long run the more important constituent. PHC in the poorest coun-tries should strive to encourage and actively include community physicians in its activities in order to achieve this combined top-down and follow-up approach to PHC. Even more ur-gently, community health workers in voluntary agency and research and development institutions seem at present to be the only ones who can continue to spearhead the bottom-up development of PHC at the grassroots level. ■

WHO/W. Brieger

Until the villagers take action to protect their water supply, contaminated sources like this will continue to plague them with guinea worm.

NIGERIA spans 356,670 square miles of West Africa, with Benin, Niger, Chad and Cameroon as its neighbours. Its population is 115,100,000 and its capital is Lagos. ■

Health photographer

Photo reportage by Paul Almasy

"Good morning, Mr Director."

"Welcome, Mr Almasy."

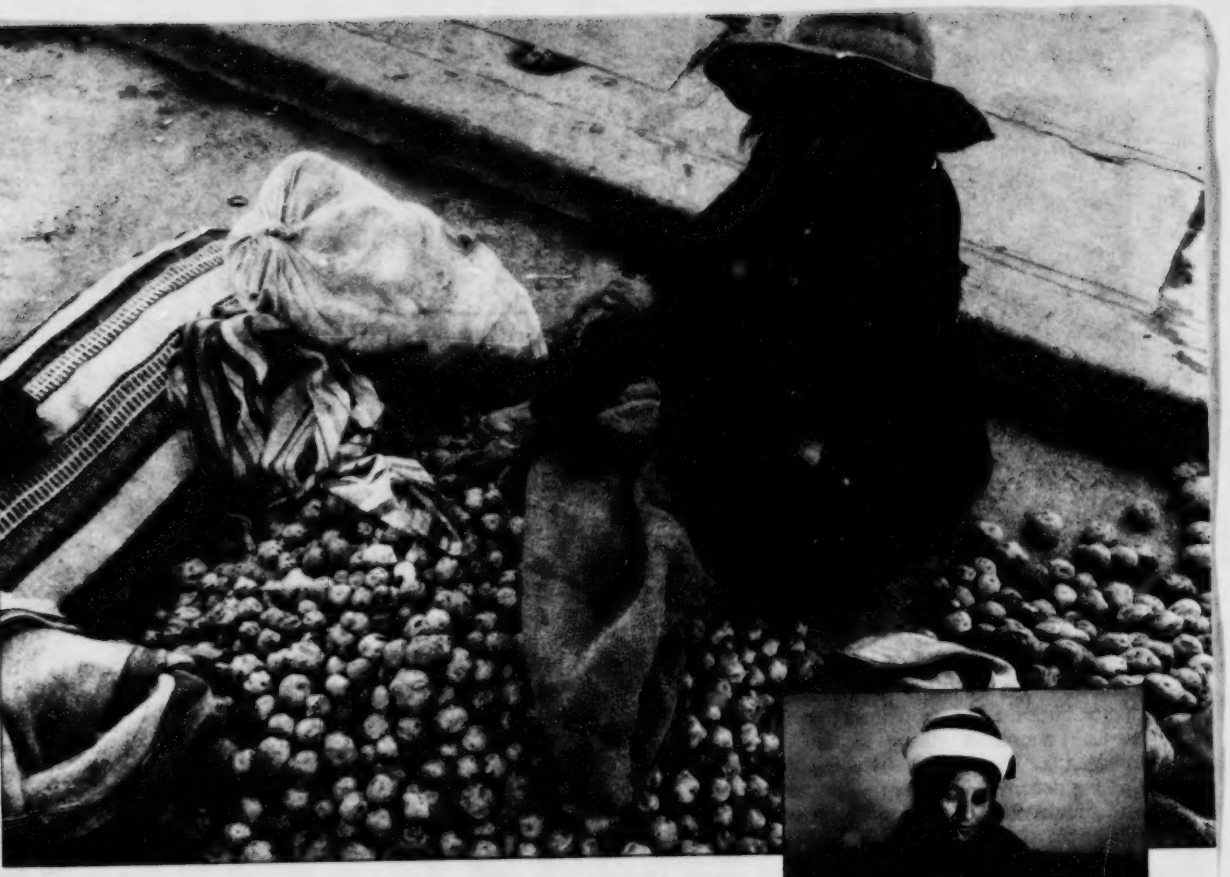
I walked into the office of Señor Ramirez, Director of Public Relations at the Health Ministry of a Latin American country. He greeted me warmly. "We've prepared quite a heavy programme for you," he said. "Early tomorrow morning a car will collect you from your hotel and take you to the new central hospital. We inaugurated it a year ago; it's a very modern hospital and I'm sure you'll admire it. Later you'll visit our big laboratory where we're getting very good results in our work on Chagas' disease. On Thursday you will have an opportunity to witness an operation by Surgeon-Professor Diaz, and you'll be able to take some photographs."

Hungarian-born **Paul Almasy** has been taking photographs for WHO – and for other institutions – for 38 years. He looks back at some of the notes he took over the years while on missions to Latin America. Today he is the Doyen of the Photo-Journalists of France.

I suppressed a smile. "Señor Ramirez, I'm very sorry, but I have to ask you to cancel this programme. It does not fit my assignment. Your country has very serious health problems and in many places people do not have enough drinking water. In the countryside there is a shortage of dispensaries. Tuberculosis is still killing thousands of people every year. I would like to see for myself and photograph the difficult conditions in which a large part of your population has to live. We do not need photographs of the clinical aspects of diseases. I have to show pictures of the causes of the diseases your people are suffering from. I have to get pictures of the situations that are begging for solutions. Your government has asked for a lot of money to help you solve those problems and our people in Geneva will soon be considering your request. If I do a reportage showing how wonderful everything is in your country, your government won't get a cent."

Poor? Yes. Dirty? Yes. But happy!
Right: ***"I have to show pictures of the causes of the diseases your people are suffering from."***

Señor Ramirez was surprised and a little embarrassed. After a few minutes' reflection he nodded agreement. Early the following day I went into the countryside with a doctor to visit a



Top: ***This market-woman in Peru made no objection to being photographed.*** **Centre:** ***With infinite patience, a woman waits for her sick child to be treated at the health centre.*** **Below:** ***Poverty breeds malnutrition – and malnutrition kills children.***

district with a very high mortality rate. I would be able to carry out my mission.

I have reported that conversation because it has recurred many times over the years, during my travels, and at many levels, in ministerial offices, and in provincial town halls. Cancelling and replanning a programme scheduled for my work has sometimes been the biggest problem I have had to face, and one that had to be solved with a certain amount of tactful diplomacy.

Another country, another date. At Manzanares, a little village in Peru, the inhabitants had only the water from a stream polluted by the drains of a neighbouring mining town. I arrived after three days of rain and saw two little girls bailing out water from puddles in the road into a large drum. "This way Mummy won't need to walk for an hour to get water." "But you'll have to boil that water before you drink it." They stared at me. "Why?" Their question shows a terrible ignorance and the answer can be found in the health report on that district: 32 per cent of deaths are caused by diarrhoeal diseases and paratyphoid fevers.

I have kept a note I made in March 1964. It reads "water-borne diseases kill five million babies each year and spread disease to 500 million people. This situation will get worse in the years to come (!) especially in urban areas."

Another misunderstanding at Quipas, again in Peru. There, a group of women of all ages had taken on the task of building water conduits to collect water from a spring a few kilometres away. It was very pure water. When I took my camera out of its bag, I sparked off angry shouting: "Tourist! Gringo! Dollar! No photo! Vayase!" One of the women had already picked up a large stone. I retreated to the town hall where the mayor received me very courteously; we went back to the construction site and the mayor explained to the women who I was and why I was taking photographs. "That's why WHO is helping us; this gentleman is doing us a favour!" After that they were all smiles. Indeed everything went so well that one of the women invited me home to taste the cake she had made for her son's 18th birthday.

I leafed through my travel notebook for 1973. The first page was headed "Venezuela – Medicatura." As I read the notes I relived the events in Ciudad Ojeda, near Maracaibo, at a rural dispensary called a *Medicatura*. It was the health unit for a zone covering

Health photographer

"Today we are going to eat meat."

six villages, and it had four beds for patients. It was staffed by an auxiliary doctor, Señorita Larreal, who was born at La Laguna, a village of 1,600 inhabitants. The regulations required that the person in charge of a medicatura should come from one of the six villages in the zone, so that all the inhabitants of the region would have known him or her since childhood. The people trusted her and she spoke the local dialect. It was a tried and tested system.

The dispensary was never idle; there was a phone call every ten minutes from someone asking for a piece of advice or a visit. Acting on the first call, we took a canoe to visit the home of a young woman who had delivered an infant and felt unwell. When we found she had a fever we returned quickly with an urgent warning for Dr Ferrer, head of the health centre of the region. Another call came from a nearby village and for that we went on a bicycle. A farmer had received a visit from his sister-in-law who lived in a region where there had recently been a smallpox epidemic. He wanted vaccinations for himself and his family. We received a friendly welcome everywhere and I was always asked what I intended to do with the photographs. Of course, I had to promise to send them one. I usually tried to keep my promise.

In the *favelas* of Rio de Janeiro I took photographs of dwellings that were so insanitary as to be almost unbearable, humanly speaking. In the suburb of Callao, a little girl called Luisa, aged eight, showed me a rat that her brother had killed. She said: "Today we are going to eat meat." ■

EQUATORIAL GUINEA
Hope for the future

by Patricio Rojas

An emergency situation – this is how the national authorities have described the present state of health and health services in Equatorial Guinea, a small country with a population of 340,000 situated on the Gulf of Guinea, in Central Africa.

A decade under a repressive regime (1969-1979) left the public services virtually derelict and brought about the collapse of internal and external communications, a drastic drop in agricultural production (cocoa, wood, coffee), the drying up of foreign investment and a steady exodus of the few nationals who had been trained for the production, service and administration sectors. Violations of human rights forced nearly one-third of the country's population into exile. The end of the dictatorial regime in 1979 afforded a chance to draw up plans for democratic rule and national recovery aimed essentially at ending the social and economic chaos, revitalising national development and improving the living standard.

But in spite of tremendous efforts and the sustained support of friendly countries and international agencies, the country's situation remains critical. Thus for instance there has been no significant improvement in indicators of health and the quality of life in recent years. Indeed, some of these indicators remain alarmingly low: infant mortality is estimated at 145 per 1,000 and no more than four per cent of the population has access to drinking water.

Dr Patricio Rojas is the WHO Representative in Malabo, Equatorial Guinea.

Equatorial Guinea is confronted by a whole range of health problems, from the virtual ruin of most of the physical infrastructure in the health sector to acute shortage of all types of resources. The absence of any integrated health development strategy has also prevented more rational use of technical and financial assistance from bilateral and international agencies. So the real challenge is to define objectives, establish priorities and draw up realistic action plans at a point where the country's needs are pressingly urgent.

Drastic problems call for bold measures. In Equatorial Guinea, general mobilisation is under way to

A health volunteer in Equatorial Guinea numbers each household during a malaria case-finding campaign. **Facing page:** ***Street scene in the capital, Malabo.***

WHO/P. Rojas

WHO/P. Rojas

promote health development from the highest political level down to the People's Councils throughout the country, of which there are more than 1,500. The overall objective is to establish a health infrastructure based on primary health care in the next four years; the government and health workers have joined forces with ordinary people of the country to try to make Health for all a reality by the year 2000.

WHO has actively helped the health authorities based in the capital, Malabo, to identify priority problems and channel human, material and financial resources to tackle them. Efforts are afoot too to draw up strategies for the health sector, to coordinate the best possible use of resources from bilateral cooperation and international agencies, to involve other agencies of the UN system in health programmes, and to concentrate WHO resources in priority areas and encourage inter-agency projects to deal with urgent problems.

Three-phase scenario

WHO's technical cooperation programme for Equatorial Guinea has steadily been intensified. A three-phase scenario for health development promulgated by the Regional Office for Africa gives due attention to the needs of the local, intermediate and central levels of the health sector. Four projects funded by UNDP, UNICEF and the World Bank are now under way, with WHO as the executing agency. In a country where diarrhoea, malaria and measles have a high epidemiological profile, the need to strengthen basic programmes to control these diseases is urgent. Meanwhile, the infrastructure for primary health care must be developed, as the only means of extending the activities of these programmes and achieving adequate coverage of vulnerable groups. WHO's technical assistance concentrates precisely on these programmes, both in their technical aspects and in the more general areas of management and administration.

WHO is now putting into effect six projects funded from the regular budget and four with extra-budgetary funding which address the country's most urgent health needs. In addition, a special fund has been approved by the Regional Committee for those countries which qualify as the least developed in Africa. In the case of Equatorial Guinea, this fund has been used to build or rehabilitate health centres for urban fringe areas, to equip emergency units in the national referral hospitals, to provide supplies of essential drugs and to strengthen the Ministry of Health as an institution.

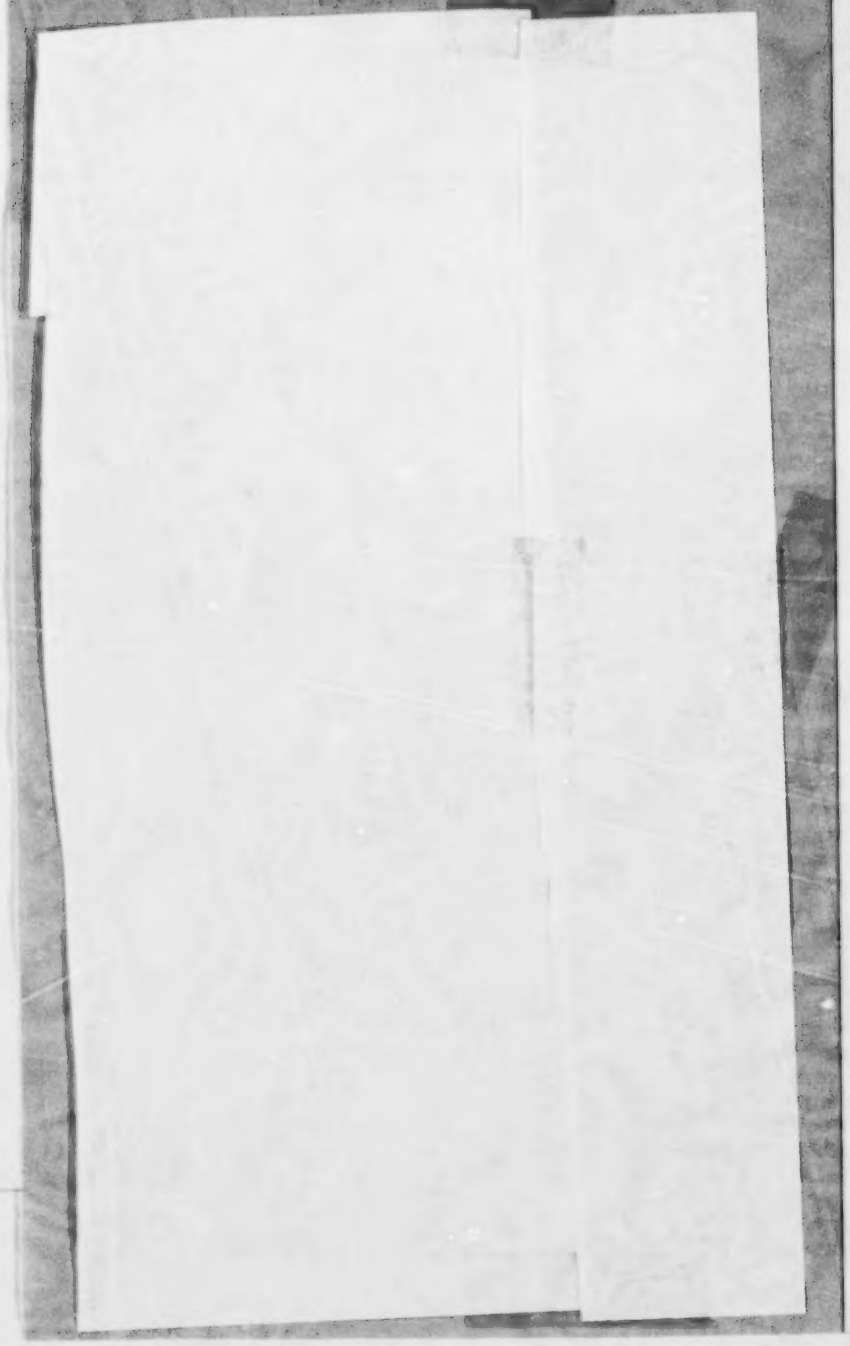
Since coordination is vital to ensure that all resources available for health are properly used, WHO has forged close contacts with the bilateral cooperation agencies at work in the country, particularly with the Spanish Cooperation Agency, which maintains 70 per cent of the primary health infrastructure in all parts of the country.

EQUATORIAL GUINEA adjoins Cameroon and Gabon on the Western coast of Africa. Covering 10,800 square miles, including the island of Bioko (formerly Fernando Po), it has a population of 340,000 and its capital is Malabo. ■

These efforts and resources alone will not suffice to guarantee the success of health development activities. Indeed, without the organized involvement of the community in these tasks it would be difficult, if not impossible, to lay the foundations for any improvement in health anywhere. Fortunately, Equatorial Guinea has a strong and extensive network which is well-fitted to mobilise communities in health activities. With the agreement of the People's Councils, the projects of WHO and other agencies are bringing about a community-based infrastructure for health, which is the key to attaining Health for all. And so, although the health situation is still far from being under control, it is nevertheless possible to look to the future with a considerable degree of optimism. ■

GUINEA-BISSAU
An ailing health service

by Isabel Maria Garcia de Almeida



With a very high illiteracy rate, an annual per capita gross domestic product of US$ 170 and a heritage of 500 years of colonisation – it has been independent for 15 years – Guinea-Bissau is one of the poorest countries in Africa. In this historical, social, economic and cultural context, it seems insane to hope to raise the populations to a state of "complete physical, mental and social wellbeing."

Nevertheless the government supported the Declaration of Alma-Ata (1978), adopted at once the strategy of primary health care (PHC) and took the decision to put it into effect at village level through community health workers attached to the basic health units.

The health centres are expected to keep the basic health units under constant supervision by providing continuous refresher training for the community health workers, supplying materials and essential drugs, evaluating the health process and identifying problems with a view to solving them or referring them to other facilities. But how could the supervision system be made effective?

Dr Isabel Maria Garcia de Almeida is a nutritionist with the Ministry of Public Health of Guinea-Bissau.

When we adopted the PHC strategy, intensive efforts were made at the local (operational) level, leaving the intermediate and central levels more or less on the sidelines of this new health concept and strategy. The health centres (the first referral level of health care) have not been developed at the same rate as the basic health units, either as regards content or as regards human and material resources. This has produced a bottleneck in the system, and the same thing is repeated at higher levels.

Without supervision, refresher training and supplies, the health structures are deteriorating; the health workers and technicians are losing their qualifications and becoming discouraged; while the community, whose participation represents an

enormous potential, is losing confidence in the system and tending to fall back on traditional and cultural practices, even some that are harmful. The unreliability of the roads and communications (especially in the offshore islands) make the referral and supervision system weaker and less effective.

The specialist health establishments consequently have to cope with a workload that is far higher than their installed capacity, both as regards resources and drugs. The cost of procedures is also increasing because complex resources have to be mobilised to carry out simple treatment.

Until a relatively short time ago, the state operated a policy of free health care, but the worsening of the economic crisis and restrictions on public expenditure made it necessary to recover the costs of health care and to introduce privatisation in this area.

Since qualified health personnel are lacking, training is an area which ought to be given priority, but so far the Ministry of Public Health does not even have a manpower training plan. How can this sector be evaluated? How can it be brought into line with needs and requirements? How should it be planned and developed?

When we refer to training we do not confine this only to health workers but also to workers in related areas and to the community as a whole. The PHC strategy presupposes multi-disciplinary and intersectoral government approaches and actions by the government, with the full involvement of the community which naturally requires at least a minimum level of training and information on the part of everyone concerned. One of the most sensitive points about putting PHC into effect is the community's ability to manage essential drugs and the resources generated by their sale.

Despite many attempts and initiatives, it has proved extremely difficult to define and carry out a partnership strategy, so that in practice the institutional health sector has become isolated and bears all the responsibility for health care. In the quest for intersectoral approaches to health, an interministerial committee on child protection has been set up under the auspices of UNICEF. At the suggestion of this committee the government formed a technical group on public health, which is carrying out an analysis of the entire health system in order to identify the principal bottlenecks, the needs and possible solutions.

In this context, it would be a mistake not to mention the current crisis in the civil service in Guinea-Bissau. Salaries are derisory (a doctor earns the equivalent of US$ 30 per month) and the latest policy of liberalisation adopted as part of the "Structural Adjustment Programme" places the civil service in a very difficult situation. The need for survival or to maintain certain living standards or lifestyles is forcing civil servants to seek more and more types of productive activity, to the detriment of their professional duties. How is it possible to demand responsibility and exercise authority in this context?

Compared with the salaries and living conditions of the national experts, those of the expatriate experts in most cases represent a social anomaly (the salary of these overseas experts averages US$ 4,000 per month, yet very often their training and experience is no better than that of the national staff.)

The main obstacles to health development in our country can be summed up as follows:
- no detailed and refined health strategy
- inadequate management of resources
- shortage of drugs
- inadequacy of human resources, especially in qualitative terms
- weakness of the national supervision system
- very poor access to information and statistics
- limitations to the intersectoral approach
- health workers losing their motivation.

One of the government's strongest partners in development is undoubtedly WHO. This Organization, the most specialised development partner in the health field, has the task of analysing and proposing policies, strategies and guidelines for member countries. Its role is therefore clearly to act as a sensitive barometer and as the government's chief adviser in the health sector as actively, honestly and competently as possible. The local representative of WHO and his advisers unquestionably have a very thorough knowledge of the Organization itself and of the country's health situation. WHO therefore acts as a powerful radar device so that, together with local experts, it can carry out its mission towards the government and provide better supervision and guidance for the temporary advisers who, as a general rule, are unfamiliar with the historical, political, economic, cultural and even health aspects of the country.

GUINEA-BISSAU lies thousands of miles north-west of Equatorial Guinea on the "bulge" of Africa: it adjoins Guinea and Senegal and has a population of 929,000 in an area of 13,950 square miles. The capital is Bissau. ■

In our view, technical assistance would produce much more favourable results if it were directed towards:
- improving and strengthening health policies and strategies
- doing something relevant and directly useful rather than finding jobs for people from supplier countries
- greater transfer of knowledge and skills
- the use of local resources, both human and material, wherever possible (this would undoubtedly reduce the costs of funding, improve the financial situation of the national staff, strengthen their experience and career prospects, and produce greater national self-confidence and self-reliance)
- put greater emphasis on the use of technical assistants from the African region. ■

THE REPUBLIC OF GUINEA

Planning for the year 2000

by Alpha Télli Diallo

"Health for all by the year 2000" is a slogan to be found at the end of most speeches and publications on health in the developing countries. But more and more countries, including the Republic of Guinea, have decided to place the slogan at the head of their speeches on national health policy. The objective is thus stated from the outset, and speakers and writers then go on to define the strategies and activities that are needed to attain it.

One of the strategies developed as a result of close cooperation between Guinea and WHO (that is through WHO headquarters, the Regional Office in Brazzaville and the national office in the capital Conakry) is a detailed exercise in health planning: the preparation of a "plan for the development of the health sector in the Republic of Guinea 1990-2000," accompanied by a financing plan for the three years 1990-1992.

The health profile of this country is similar to that of others in West Africa. Infectious and parasitic diseases predominate, and health indicators remain well below the levels which could be attained. The government therefore asked WHO to assist national experts to determine ways and means of achieving the best possible use of resources allocated to the health sector.

Carried out in the third quarter of 1988 and the second quarter of 1989, this exercise did not in fact start from scratch. In 1984, a document entitled "Country resource utilisation" (CRU) had been drawn up by the Ministry of Health in collaboration with consultants from WHO. It described the primary health care policy and strategies adopted and practised by the country, the resources available to the health sector and an outline of planned activities, including how many facilities were to be opened each year in order to provide acceptable health care to all communities of 600 to 1,000 inhabitants, at a price they could afford. Particular emphasis was placed on the need for an extensive network of village health units. No budget for this network was proposed, but given the country's limited human, material and financial resources, it was obvious that this scenario was unrealistic.

The CRU was revised in 1986 by a joint Ministry of Health/WHO team. But the new version still presented the same problems of substance. Moreover, nothing was done between times to mobilise additional resources to meet the needs set out in these plans. The Ministry of Public Health and Population decided to concentrate especially on health planning and to programme all its activities. It set up a division of studies, planning, training and research in the area of health, and put together step by step a general health policy and a health development plan (1986), followed by two health action plans (1987 and 1988).

A further revision of the CRU document was then envisaged by the two parties. This time the idea was not simply to update the existing document but to innovate in substance and in form, so as to produce a basic document whose provisions could today be realised in the short term. The conventional CRU format was abandoned and a "national health development plan" looking forward to the year 2000 was produced instead.

The need for a document of this kind was felt at all levels of the Ministry of Health and by all its partners from abroad or from outside the system. The government then attached a plan for financing to see what the full health development plan would cost the nation. This involved arranging a meeting of donors for the health sector.

In view of the country's social and economic conditions, the government has drawn up a national recovery plan, giving priority to road infrastructure, transport, mines, energy, water and rural development (to promote self-sufficiency in food). Reconstitution of the country's economic fabric will enable it to raise its income in the medium term (three to five years) and thus to devote greater resources to the social sectors, such as health, in the long term. For the transitional period, however, the government will appeal for foreign resources to finance the vital investments needed to bring about an improvement in the country's situation, hence the addition of an investment plan for 1990-1992.

Dr Alpha Télli Diallo is Director of the Office of Studies in Planning and Research, Ministry of Public Health and Population, Conakry, Guinea.

These documents were prepared by a multi-disciplinary team comprising the directors of Ministry of Health departments and consultants from WHO, Geneva, who undertook a thorough analysis of the health sector in the third quarter of 1988, identified needs and selected priorities in conjunction with the national health authorities. The consultants returned to Geneva with a vast stock of information and the general outlines of a number of projects which might attract funds at a meeting of donors. The first version of the plan was written up in Geneva and sent to Guinea, where copies were distributed at all levels in the Ministry of Health and the other ministries involved – the Ministry for the Plan and International Cooperation, the Ministry of Economy and Finance, the Ministry of National Edu-

REPUBLIC OF GUINEA has as its neighbours Guinea-Bissau, Senegal, Mali, Côte d'Ivoire and Liberia. With 95,000 square miles, it has 6,147,000 population, and its capital is Conakry. ■

ation and the State Secretariat for Decentralisation.

In the light of the responses eceived, a second version of the locument was reviewed by an impor- ant WHO Mission (headquarters, re- ional and subregional offices), and it vas decided to bring in a new team of consultants to improve the economic nd budgetary part and produce the document in a form suitable for a meeting of donors. This work was undertaken in close collaboration with national experts from the health and other ministries, and offered a valuable opportunity for nationals to gain experience in drawing up such documents – one of the major concerns of the Guinean authorities.

The result is a national health development plan (1990-2000) with a financing plan for three years (1990-1992). Primary health care will be introduced in the country with six specific additional goals:

- the establishment of a national epidemiological analysis centre;
- reinforcement of the national public health laboratory;
- the strengthening of communicable disease control;
- better facilities for making nutritional surveys;
- setting up of a personnel re-training and documentation centre;
- a study of traditional medicine with a view to integrating it into the national system of primary health care.

The next stages will be the final editing, printing and publication of the document; arranging a meeting of donors; and preparing detailed plans of action for each of the projects adopted so that activities can rapidly be started.

The government has already been assured of WHO's support in all areas (human and material resources) both from headquarters and from the regional, subregional and national offices. Besides mobilising external resources, this exercise has proved its worth by providing the sector with a long-term development plan, while team-work with competent experts has helped to improve national skills in health planning and has resulted in basic documents being drawn up for the health sector. ■

WHO/C. Stauffer

Just imagine!

by Charles Boelen

Facilities are minimal in this East African hospital. Could they be improved if the people in charge showed more creative imagination?

"I'm doing fine, thank you!" We were surprised to hear that from the dental technician of a rural African hospital, especially after the litany of complaints we had heard from most of the staff in the other departments, some lamenting the lack of resources and others the difficult working conditions.

But this technician was a ray of sunshine – and it was easy to see why: the single room he had to use as waiting room, office and surgery had everything. The dentist's chair had been put together from car seats salvaged from cars abandoned beside the nearby national highway. The chair could tilt and swivel, it had a foot-rest and a head-rest, all home-made with the help of a blacksmith friend. It was a triumph of ingenuity. The drilling machine had been made from a discarded hand-drill.

True, this is just one anecdote, but it does teach us something. We cannot help but think that the health system, and consequently the health situation, of the poorest countries would be much better if all the people in charge of health care had such creative imagination. A country, like an individual, is on the road to development when it controls its own destiny, when it is in full possession of its resources, when it is able to remove the obstacles to its full realisation.

Do the countries generally designated as "least developed" really control their destiny; are they today in charge of their own health development? Probably not. This is due as much to wastage of human and material resources as to general shortage of such resources; it can be attributed even more to lack of imagination, or lack of encouragement to use imagination to make the best of resources.

Plenty of reports attribute the critical health situation of poor countries to political instability, inadequate infrastructure, incompetent management, absence or migration of managers, chaos, natural disasters, even general indifference or pessimism, or a combination of these factors. Such reports are certainly revealing, but they are too gloomy and do not offer enough hope. Let us look more positively at the real potential for development that those countries have.

The one natural resource that all of

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them have in abundance is the human resource. Unlike gold or diamonds or oil or copper, there is no need to dig for human beings because there are such great numbers of them easily available and ready for work. But this raw material has not yet been sufficiently refined to make it a formidable potential for health development.

Reservoirs of talent

To achieve this, major transformations are needed in the educational system, especially in health manpower training institutes and in health service management. In universities and schools, for example, which should be reservoirs of talent, we might have expected to see the training of managers and personnel with urgently needed skills. Yet this is rarely the case. Let me cite the communicable diseases department in a university hospital in one capital city which suffers a resurgence of cholera every year. How can it be that neither teachers nor research workers nor students have had the initiative to instigate multidisciplinary activity in the health services and the community which could put an end to this affliction? Meanwhile less than a kilometre away in another university department (neurosurgery), a national première of the excision of a brain tumour is being filmed for television. The eradication of cholera would have been at least as impressive an achievement.

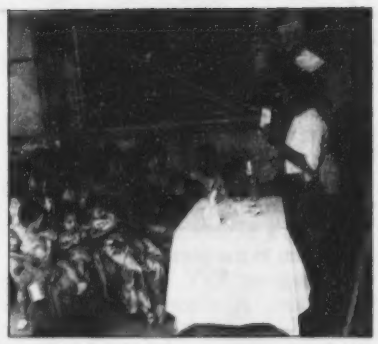
Most training programmes are neither conceived nor run in such a way as to provide society with enterprising health managers. Indeed, the very aims of training are rarely expressed in terms of confronting the real health challenges to individuals, families and communities in the country. Quite often, more attention is paid to a rare disease than to one that is prevalent in the country. Furthermore, apprenticeship frequently tends to be simply imitation of the teacher by

the student, so that the latter has no active and independent part to play in his or her training, or any experience of problem-solving.

Common sense may be thrown to the winds. In one poor country, for example, I have seen nursing instructors being taught research methodology. The students were asked to devise a project that would investigate why mothers did not frequently attend nutritional education sessions at the health centre. They could have saved themselves the trouble of preparing a ponderous and scientific-looking survey if they had simply realised that most of the mothers lived more than an hour's walk away from the health centre. This is a case where the teaching of a technique did not encourage the students to display imagination. A tour of the area, a group discussion and a role-playing exercise would have been a better approach. Imagination cannot remain an attitude of mind, but must be considered a basic asset for all health workers that guides their work and becomes a professional ethic.

Health services should therefore encourage this virtue, since it helps them to function better. In underprivileged countries one often finds working practices that have disastrous effect on the viability of the health system – the physician who prescribes five drugs of dubious merit to a patient who will spend one-tenth of his salary on them, the state-registered nurse working as a receptionist in a district clinic that is terribly short of qualified staff, the ambulance driver who chauffeurs his boss home every evening. Such practices soon dampen the enthusiasm of any new recruit, who quickly joins the ranks of those who have given up, lost motivation or just become lazy.

Putting a shoulder to the wheel in Bangladesh. The one resource that even the poorest countries have in abundance is the human resource. Right: ***Oral rehydration demonstration in Burma; health workers need to learn skills that are relevant to the local context.***



WHO/UNICEF/S. Maines

Forty years on

What is the condition of health service development in especially poor countries, more than 40 years after the establishment of WHO, more than 30 years after their liberation from colonial dominion, more than 20 years after intensive training of managers and staff to assume responsibility for health, and more than 10 years after the Alma-Ata Declaration on primary health care and the unanimous adoption by the community of nations of a resolution to endow health systems with more equality and social relevance?

Many feel the situation is still worrying. Is the international community going to respond by granting massive aid to these countries, rapidly transferring technologies, accelerating the training of staff and consolidating cooperation? That script has already been written and it does not seem to have provided clear results. Now it is the national and foreign planners and decision-makers who are expected to show imagination, and to test new and more realistic approaches that take account of the real obstacles to health development. These should be based on new and ostensibly contradictory paradigms that yet give better expression to the problems of health in the poorest countries. The planners must look for a compromise between rapid action and long-term development; they must combine pragmatism with rigorous methodology; and they must encourage positive interaction between national determination and increased international assistance.

In short, words, greater frankness and a new ethic of partnership for development are needed now. Since people are capable of imagination, giving priority to the improvement of manpower is still the best way out of under-development. We have to recognise the power of imagination and admit, with Albert Einstein, that imagination is more important than knowledge. ■

RWANDA

Mental care for all

by Franz Baro

"Doctor, there's a new patient – and it's a man and a woman at the same time!" cried the nurse, very excited, interrupting my dinner. I had just arrived and it was my first evening in Rwanda, in November 1978. I was staying at the Ndera Neuropsychiatric Centre and had asked to be called as soon as a new patient was admitted.

The agitation of the staff was understandable. The physical appearance of the young man of 18 brought by the mayor of his village was indeed strange: he had well-developed breasts but his penis was that of a child. From my experience of genetic disorders, I was certain that this was a case of Klinefelter's syndrome, a genetic aberration due to the presence of three sex chromosomes, XXY. The effect of the superfluous X chromosome is that males (who normally have XY) develop breasts at puberty, while their male organs fail to develop beyond their childhood state, resulting in sterility.

On examination, the young man, whose name was Séraphin, proved to be ecstatic at the idea that he was "pregnant of himself." The mayor told his story. Séraphin had become an orphan at puberty and had been charitably adopted by the neighbours. At that point he was quite normal. It was only later that his problems began. His aberrant sexual development made him the laughing-stock of his peers. Neither he nor his adoptive parents understood what was happening. The healers they consulted were no help. Séraphin gradually sought refuge with his adoptive mother who lavished care upon him. When he reached the age of 17, he demanded the sexual initiation of which he was so cruelly deprived. His mother, frightened, told her husband, who punished Séraphin mercilessly for what he described as "misconduct and ingratitude."

The mayor had to intervene to save Séraphin from the worst. He forbade him to stay any longer with his adoptive parents and, in a spirit of solidarity, gave him a hut and a plot of land above the village in the hope that he would manage. But Séraphin soon became totally isolated from the community. Then, a few months later, he came running joyfully down to the mayor and announced that God, who had created him man and woman, had permitted him to impregnate himself, and that in a few days' time he would give birth to a very special child. Flabbergasted by these deluded ramblings, the mayor decided to bring Séraphin to the hospital at Ndera.

Thus, like most patients, Séraphin only came into contact with the mental health service after a long evolution of his condition and the failure of traditional healers. Among the people of Rwanda, mental disorders are traditionally perceived as a battlefield for invisible forces – God, local spirits, dead ancestors, sorcerers and enemies. Evil, represented by the disease, is always the effect of another evil. Any therapy which hopes to succeed must confront the disease in the no material realm. To enter this wor protection and the long experience the healer are needed. The contine of Africa is a mosaic of cultures with amazing variety of traditional therape tic practices. In Rwanda, therapeu rituals are often addressed Ryangombe, a divinity who is t source of peace, love and fertility.

This traditional medicine should n be underestimated or rejected modern medicine. Besides the cultu affinity between the patient and t healer, the fact that both belong to t same community – where the hea commands great authority – helps make patients and their families fe more secure. The assistance of heale helps mental patients, for as long they abide by family and public ord they will never be locked up.

Dr Franz Baro is Professor of Psychiatry at the Catholic University of Louvain, and Medical Director of the University Psychiatric Clinic Sint-Kamillus in Bierbeek, Belgium.

To encourage the integration traditional medicine, the governme of Rwanda has set up an association healers, though no evaluation of th methods of treating mental diseas has yet been possible. Modern me cine tends to demystify certain poo understood concepts such as poiso ing and magic, and to emphasise t need for proper diagnosis a treatment. In the case of Séraphin, example, one can hardly attribute genetic accident (XXY) to the "e eye" or the transgression of a tabo Simultaneous recourse to tradition and modern therapies gives rise serious ambiguity, as there is no inte ration between these two disciplin Senior officials often disparage t procedures used by the healers but s consult them discreetly for their o and their families' problems. Contin ing collaboration between the men health services and the healers as well-organized group is needed overcome this ambiguity.

Mental health services have on recently been introduced in Afri Some people even maintain that t problems of infectious diseases a malnutrition are so great that it premature to provide mental hea services, given the limited resourc With a per capita gross nation product of US$ 260, Rwanda

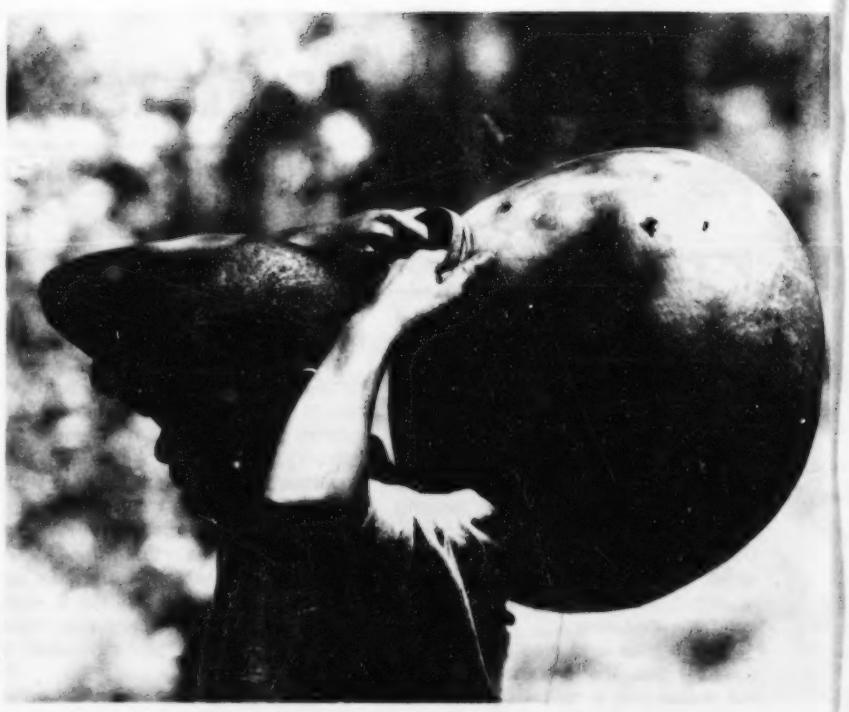
classified among the poorest countries. This small, landlocked country in the heart of Africa, known as the "land of a thousand hills," has a scattered population living in isolated farms and is criss-crossed by an extraordinary patchwork of small fields, with only a small area of bush, forests and swamps. For health, the annual per capita spending of US$ 2 falls far short of the needs. Health personnel are lacking, with one doctor on average for every 25,000 inhabitants, one medical assistant for every 18,000 and one nurse for every 7,000. The population (90 per cent rural) is now over seven million (a density of 265 per square kilometre), and is increasing at an annual rate of 3.7 per cent; it is feared that it will exceed 10 million by the year 2000. The country's predominant policy concerns are self-sufficiency in food and control of demographic growth.

For 20 years, however, the Rwanda government has been convinced that the prevalence of mental illness justifies the same active intervention as in other medical fields. Collaboration between the government and the Congregation of the Brothers of Charity made it possible to open the "Caraes" Psychiatric Centre, with 120 beds, in 1972 at Ndera, near Kigali, the capital. Soon between 1,500 and 2,000 urgent cases were being admitted each year, while consultations rose to 10,000 annually.

Three objectives

In 1975, Rwanda approached WHO for special collaboration, with three objectives: to make mental health care available to all the population; to integrate mental health care into the primary health services; and to place emphasis on prevention. Overseas cooperation, especially from Belgium and France, helped to implement this programme. Anxious to cooperate with the African Mental Health Action Group, Rwanda joined this group in 1977. During the last decade, it has carried out such activities as training in mental health, starting up a specialised dispensary and building sheltered housing.

But the most important step has been and continues to be the integration of mental health care into primary health. There are now 15 health centres providing mental health services, which are accessible to patients from two-thirds of the country's communes. These centres are visited regularly by a mobile team from Ndera, consisting of a physician, a medical assistant, a nurse and a social worker. The team helps the staff to assess the patients and set up the necessary treatment. The staff receive further training in the form of a one-month refresher course at Ndera every two years. In this way, nearly 10,000 patients are being followed at the pilot centres by rural personnel supervised by the mobile teams, and few of them need to be confined to hospital.



WHO/Zaldar

A water-carrier cheerfully bears his load. The burden of mental ill-health afflicts poor countries as well as rich; Rwanda has recognised this and is trying to make mental health care available to all the population.

There is no shortage of problems. It is difficult to obtain supplies of psychotropic drugs. Inadequate training leads to mistakes in treatment. Overcrowding at Ndera results in early discharge of patients, unmet needs and overwork for the staff. Mental health consultations need to be available in all the general hospitals, with a few beds for serious cases of acute psychoses. A division of mental health is needed at the Ministry of Public Health to improve coordination and evaluation of the national programme. Legislation on mental disorders is also needed, so that patients are not neglected, maltreated or unreasonably deprived of their freedom and rights. Rwanda is one of the countries where the incidence of AIDS is reaching alarming proportions and this will particularly test the mental health services; mental patients are a risk group for infection, while AIDS may in turn give rise to mental and neurological problems.

RWANDA is a landlocked republic with Uganda, Zaire, Burundi and Tanzania as its neighbours. Its population in an area of 10,200 square miles is 7,276,000, and its capital is Kigali. ■

Better understanding

So what became of Séraphin? With the help of treatment, his delusions disappeared after six weeks. He was able to return and settle in his village, which has shown solidarity through better understanding and acceptance of his psychosexual handicap. There can be no doubt that getting to know each other better – Africans and non-Africans – and working in closer cooperation will lead us to a practice of mental health in which our values and knowledge are reciprocally respected and enhanced.

The success of the integrated mental health care project in Rwanda will depend on the combined efforts of national and international agencies, the devotion of the health personnel and the support of all those for whom the promotion of mental health is important for the country's future. ■

Polio in the Marshall Islands

by Deborah A. Goebert

The Marshall Islands, isolated in the Pacific Ocean, experienced a polio epidemic well after the first development of the polio vaccine. In 1963, a young Marshallese visiting the Kwajalein military base became contamined with the polio virus. The disease spread out across the virtually un-immunized population, causing impairment in nearly 200 people. Dozens remained permanently disabled. Today, over 25 years after the epidemic, new problems related to polio are appearing.

With a total land area of about 70 square miles, the islands are spread out across half a million square miles of the West-Central Pacific Ocean, and lie a few degrees above the equator. The Republic of the Marshall Islands is comprised of over 1,000 islands, atolls and islets, but only a few are inhabited on a permanent basis. The total population is around 43,000, and the capital is Majuro.

An epidemic of gastro-intestinal illness resulting in transient muscle weakness in children and adolescents was reported in 1958 in the Marshall Islands, which were then a district of the U.S. Trust Territory of the Pacific Islands. The outbreak occurred after a regional meeting which was attended by delegates from all areas of the Pacific. Although the clinical diagnosis of poliomyelitis could not be confirmed, a Salk vaccine immunization programme was begun among the residents of Majuro. Unfortunately, all efforts had ceased by the end of 1959, partly because there had been no formal reports of paralytic polio.

In the latter part of 1962, several families from areas which had suffered recent outbreaks of poliomyelitis moved to the Marshall Islands. In January 1963, an American girl developed a non-specific illness with symptoms which included fever, malaise, headache, dizziness and vomiting. Three days later, she experienced paralysis which would later be confirmed as polio virus Type 1. And five days after the onset of this initial case, a Marshallese boy developed a similar illness.

In the next two months, polio spread throughout the Marshall Islands – following in the wake of two cargo ships and a local schooner. At each of the atolls visited by the ships, the passengers (including children) would disembark, spend a few nights ashore, and then continue the journey. Not long after the ships' visits, new cases of paralytic polio were identified. A total of 196 cases were recognised in the Marshall Islands during the 1963 epidemic. Of these, 194 occurred among the indigenous population, who numbered only 16,000 at that time; 90 per cent of those afflicted were children under the age of seven.

After polio was confirmed, the authorities used vaccination and quarantine to limit the outbreak and confine it to the island group. But of course these efforts could not help those already contaminated impaired by the virus.

A clinical appraisal on all the pe who had polio, made some 30 after the onset of paralysis, rated person on a 1 to 5 scale accordi the severity of involvement. result, 37 individuals (19 per were classified as Class 1 – par polio with no residual paralysis individuals (35 per cent) as Clas minor residual paralysis; 51 indivi (26 per cent) as Class 3 – signi residual paralysis leading to funct impairment of one or more limbs 29 individuals (15 per cent) as Cl – severe involvement leading to o more limbs being extremely inv or severe trunk musculature inv ment, or both. Eleven persons per cent) died.

Rehabilitation care

Persons classed as 3 and 4 rec extensive rehabilitation care follow-up because of the sever disease. So the health authorities this need by developing a reh tation programme and openi rehabilitation centre where m treatment, surgery and phy therapy were available. Despite li tions in staff and facilities, the th programme had good results in of recovery of function. For people, therapy still continues to

In 1988, the Pacific Basin Reh tation Research and Training C of the University of Hawaii, Jo Burns School of Medicine, cond clinical evaluations and inter among 73 Marshallese who ha polio in the 1963 epidemic. Inf tion collected included demogr factors (such as sex and age); w felt like to experience polio; identification of muscle weak new health problems and s needs. This study was in respon concern about increasing evi from the United States that pe who had polio are now experie new problems related to the dise

These new polio-related problems are thought to begin 30 or more years after the onset of the initial polio episode. They include progressive loss of mobility; decreased functional independence; increased fatigue and intolerance to cold; and increased muscle and joint pain, muscle weakness and atrophy in both affected and what were believed to be unaffected limbs.

Mrs Deborah A. Goebert is a Research Specialist at the Pacific Basin Rehabilitation Research and Training Center, John A. Burns School of Medicine, University of Hawaii, USA.

It turned out that, 25 years after the epidemic, new polio-related problems were appearing in the Marshall Islands. More than half of those examined were found to have residual muscle weakness. Sixteen per cent reported increased muscle pain; eight per cent increased muscle weakness; eight per cent increased fatigue; and six per cent increased joint pain. Few individuals needed assistance in completing daily activities like walking, climbing stairs, feeding, dressing, bathing or grooming. There had not been an increase in the use of mobility aids – braces, crutches or canes – since maximum recovery occurred. Although only a few Marshallese show signs of these polio-related problems, the studies in the United States suggest that these numbers will be increasing. About 20 per cent are expected eventually to develop disabling conditions and other late effects of polio. For those who must live with this progressive deterioration, the future outlook is frightening.

Further research needs to be done in order to find ways to better understand the onset of polio-related problems and to prevent any new loss of function. At present, there is some controversy about the best therapy measures. Some believe that energy-conservation techniques should be taught to polio victims so as to minimise over-use of muscles and joints, while others believe that exercise programmes should be developed in order to strengthen and maintain muscles and joints. The evidence so far has suggested that both methods may be appropriate, but no clear criteria have been developed for effective case-management of people who had polio.

Immunization is now being aggressively pursued in the Marshall Islands, particularly on the more isolated outer atolls where it was discovered that as many as 90 per cent of the children had not been vaccinated against polio. The new "cold pack" method of packing the vaccine, supplied by UNICEF, enables the potency of the shots to be maintained for two weeks in the warm climate, and makes immunization possible even in the remotest atolls. In addition, health service personnel are training assistants from the outer atolls in primary health care, including immunization and the use of the "cold chain" recommended by WHO as a means of keeping vaccine safe from extreme temperatures.

These continuing efforts should allay fears that another major epidemic will spread rapidly through their young population. With those individuals who were stricken with polio serving as a constant reminder, the Marshall Islands authorities are now dedicated to immunizing 100 per cent of their population.

There is much that can be learned from the Marshall Islands polio epidemic. First, no matter how remote an area of the world may be, it is still susceptible to the devastation of polio. Secondly, eradication is possible but it requires constant efforts to immunize all the people. Finally, rehabilitation needs to be provided to those who are disabled from polio, both immediately after – in order to maximise recovery – and throughout their life span – in order to minimise the possible late effects of polio. ■

NEWSPAGE

Editor: Philippe Stroot

From crisis to growth

Is there light at the end of the tunnel for Sub-Saharan Africa? A recently published report by the World Bank suggests that there are "grounds for believing that recovery has started."

Sub-Saharan Africa: from crisis to sustainable growth is a comprehensive 300-page document which closely, and sometimes bluntly, analyses the economic and social position today. It comments: "Sub-Saharan Africa as a whole has now witnessed almost a decade of falling per capita incomes, increasing hunger, and accelerating ecological degradation. The earlier progress made in social development is now being eroded. Overall, Africans are almost as poor today as they were 30 years ago. This situation has spurred many governments to undertake far-reaching reforms. More than half have embarked on structural adjustment programmes. The countries that have persisted with reforms since the mid-1980s are showing the first signs of improvement. These give grounds for believing that recovery has started."

Here are some of the points made by the World Bank:

– The crisis is taking a heavy toll in human terms. In several countries expenditure on social services is sharply down, school enrolments are falling, nutrition is worsening, and infant mortality continues to be high.

– In many places political instability, coup d'états and ethnic strife are exacting a terrible toll on helpless people. And the costs of destabilisation in southern Africa have been enormous.

– Population growth has steadily risen during the past three decades. Now well over three per cent, it is outpacing GDP (gross domestic product). In contrast, in most other developing countries population growth has declined.

– If Africa is to avert hunger and provide its growing population with productive jobs and rising incomes, its economies need to grow by at least four to five per cent a year.

– *Primary health care comes first.* Major strides toward better health care are possible, even within the budgetary constraints facing African countries, if expenditures are re-directed from high-cost curative medicine in modern hospitals to preventive and community-based systems. Mass immunization campaigns are cheap and effective against several major childhood killers. And even very poor people willingly pay for health care if they demonstrably get value for their money. This above all means ensuring a reliable supply of inexpensive drugs through better procurement procedures and regular delivery to clinics and health posts.

– Two out of every three rural Africans are still without safe water. Universal access to clean water, which is a prerequisite for better health, should be an integral part of the long-term strategy.

– More and more Africans are going hungry. Severe food shortages were exceptional in 1960; now they are widespread. It is estimated that about one-quarter of Sub-Saharan Africa's population – more than 100 million people – faces chronic food insecurity.

– School enrolments have been vastly expanded during the past three decades ... The long-run goal remains to expand enrolments – especially of girls, because female education has a particularly strong effect on family welfare.

– In health care, a little money can go a long way. According to WHO, depending on the level of infrastructure development, it should be possible to provide essential primary health care with a recurring cost of US $10 per capita per year. For even the poorest countries with GNP (gross national product) per capita of around $200, the public expenditure for gradually achieving universal primary health care would be no more than two per cent of GNP, increasing to three per cent by 2000, provided measures for improving efficiency are adopted. ■

Princess Chulabhorn of Thailand, WHO Ambassador

At a special ceremony held on 1 December 1989 in Geneva, Dr Hiroshi Nakajima, Director-General of WHO, appointed Princess Chulabhorn of Thailand as a Goodwill Ambassador of the World Health Organization.

An eminent scientist, Princess Chulabhorn has a doctorate in organic chemistry from Mahidol University in Thailand. She is at present Director of the Chulabhorn Research Institute in Bangkok and takes a very close interest in humanitarian and social problems. In his address to the Princess, Dr Nakajima declared "I know that your scientific and personal accomplishments, and the traditions of your country Thailand for which I have the strongest affection, will ensure that you have lasting influence as a Goodwill Ambassador of WHO. I am convinced that you will inspire all those whom you meet – national and world leaders, your professional colleagues and students – with a common desire for the the security and peace which will enable us to harness our resources and forge new alliances in order to improve both health and the quality of life." ■

Princess Chulabhorn of Thailand with the Director-General

Research in health science

Almost 100 specialis from various European a African countries and fr India, took part in Decem 1989 in an internatio colloquium held in Antw (Belgium) under the title "Research in health scienc an indispensable tool development." Organized the Prince Leopold Instit of Tropical Medicine, w financial support particul from the Belgi Government and t European Economic Co munity, the colloqui summed up the needs tropical countries in regar health research.

Some participan deplored the imbalan which exists betwe research projects on trop diseases, which repres about 80 per cent of projects, and those c cerned with nutrition public health. Dr Gentilini Paris, said in this context there was a certain disc for operational research. speakers emphasised need for multidisciplin research, including in pa cular the social sciences, stressed the importance education and training in pical health. The interacti between health and devel ment should also be g special attention, they s since disease ecolo changed with agricult development and urba sation. It was true that new technologies offe prospects of progress in control of tropical disea but it was still necessary ensure close cooperat between North and Soutl enable those technologie be adapted to the spe problems of the develop countries.

Research in tropical health is needed today more than ever

In his concluding remarks, Dr René Le Berre, of the WHO Special Programme for Research and Training in Tropical Diseases, recalled Europe's long tradition of research on health in the tropics. Emphasising that many countries in Africa were still not in a position to cope on their own with the enormous problems facing them, he urged that research for development should be carried out through close cooperation between WHO, the EEC and the European countries as a whole. ■

Young people against AIDS

On 1 December 1989 World AIDS Day was celebrated throughout the world. Important events took place in thousands of towns and communities as well as at the headquarters of WHO in Geneva and in the six WHO regional offices.

WHO sponsored this second World AIDS Day – which has now become an annual event – in order to encourage greater awareness and better knowledge of the human immunodeficiency virus (HIV) and of AIDS, and in order to extend and strengthen the efforts being made throughout the world to prevent the infection and to care for infected persons.

The ceremony organized in Geneva to mark World AIDS Day included meetings on the theme adopted for 1989: "Young people and AIDS." WHO headquarters remained continuously in contact with events throughout the world and passed on messages of solidarity, sympathy and understanding in regard to AIDS.

Dr Hiroshi Nakajima, Director-General of WHO, himself inaugurated this World AIDS Day, which featured in particular discussions between young people and AIDS patients, and the showing of two films on the disease. ■

Newsbriefs

• **Two new Assistant Directors-General** *have been appointed at WHO headquarters with effect from 1 January 1990. They are Dr Ralph H. Henderson (United States), who was formerly Director of WHO's Expanded Programme on Immunization (EPI), and Dr Nikolai P. Napalkov (USSR), formerly Director of the Petrov Research Institute of Oncology in Leningrad.*

• **Spokeswoman.** *Mrs Thérèse Gastaut (France) has been appointed Programme Manager of WHO's Office of Information and the Director-General's spokeswoman. She was previously Director of the Information Service of the United Nations Office in Geneva. She succeeds Mrs Ann Kern (Australia), for two years Director of the WHO Division of Public Information and Public Relations. Mrs Gastaut's appointment forms part of the reorganization of information activities in WHO.*

• **African emergencies.** *In its time, Noah's Ark was an appropriate response to an emergency situation. It did not, of course, prevent the Flood but it did reduce the loss of human life ... It is not surprising, therefore, that "The Ark" has been chosen as the title of the bulletin of the WHO Panafrican Centre for Emergency Preparedness and Response at Addis Ababa in Ethiopia. As can be seen from the cover of the second issue, humour still has its place, despite the often tragic nature of the situations with which the Centre is called upon to cope. This second issue of "The Ark" includes 44 news items that relate to the management of different kinds of emergency – whether natural or man-made – throughout Africa.*

• **Better medical education.** *Deans and Directors of schools of medicine and health sciences held a three-day meeting recently in Brazzaville and drew up recommendations aimed at improving the quality of medical education in the African Region.*

WHO's Regional Director for Africa, Professor G. L. Monekosso, thanked the participants for their work and said that the fruit of their endeavours represented a sign of hope for the future. He commented that "a new movement towards education for all" had now been added to the philosophy of Health for all. ■

In the next issue

Who make up two-thirds of the illiterate in the world? Who do two-thirds of the world's work and produce at least half of the world's income? Yet who are the poorest among the poor? The answer to all these questions is: Women. The April issue of *World Health* examines the health of women and its bearing on the health of all.

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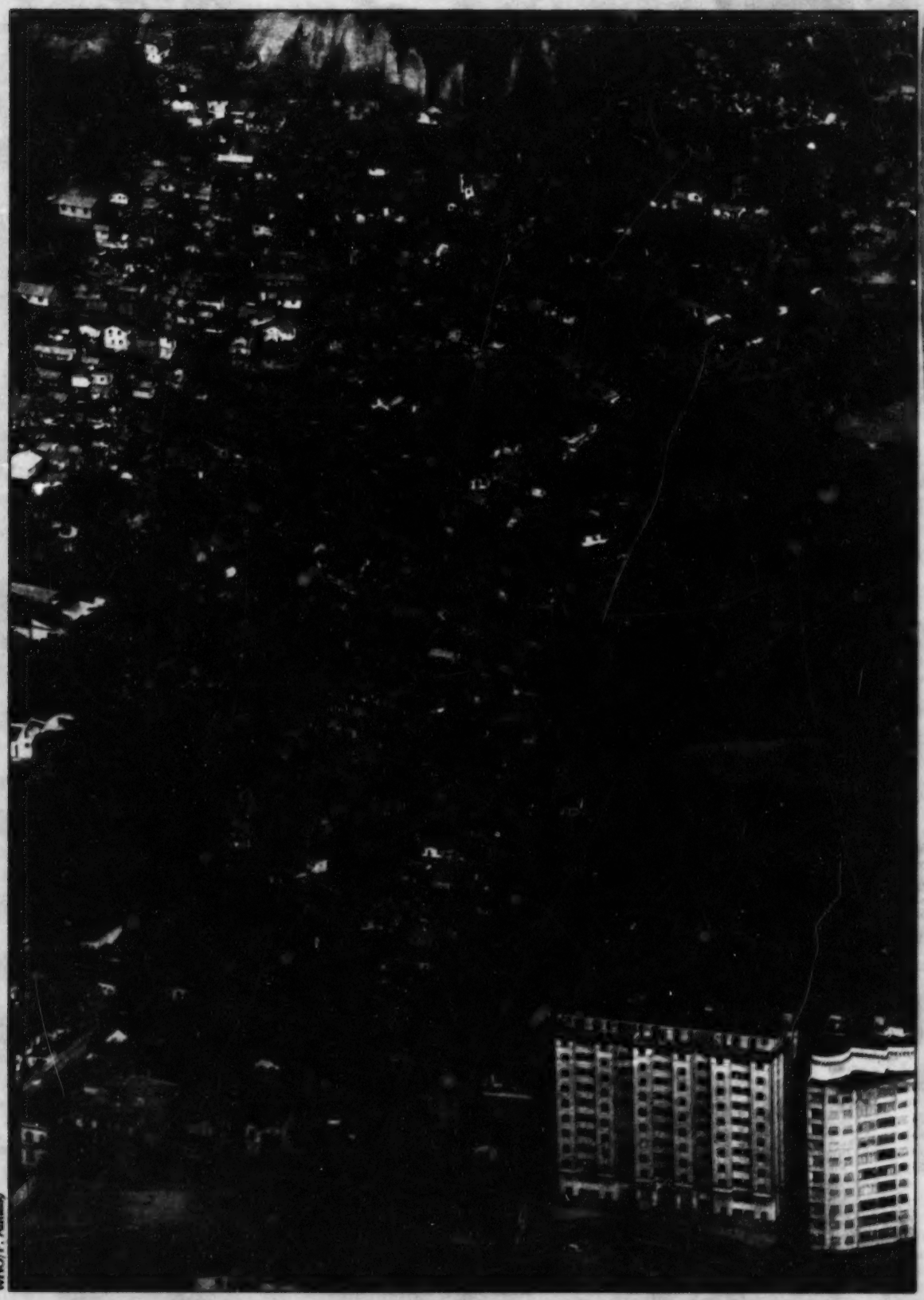

WHO/P. Almasy

"Dwellings that are so insanitary as to be almost unbearable."
See pages 16-18.

Courtesy of the World Health Organization